Date Application Rec'd	Fees Included Yes [ ] No [ ]

Application for HCO Certification

(WORKERS" COMPENSATION HEALTH CARE PROVIDER ORGANIZATION only)

Execution Page

1.a Legal Name of Applicant

1.b Please list all fictitious names you intend to use

_____

_____

2. Address

_____

_____

3. Employer Identification Number

___ ___ --- ___ ___ ___ ___ ___ ___

4. I declare under penalty of perjury under the laws of the State of California that I have read this application and exhibits and attachments thereto and know the contents thereof, and that the statements therein are true and correct.

a. Typed Name of Authorized Representative _____ b.Title _____ c. Telephone Number _____

d. Fax and E-mail _____

e. Signature of Authorized Representative

f. Date Signed

A. Type of Application

[ ] New [ ] Recertification
[ ] Amendment to Pending Application
[ ] Substantial Material Change
Items being amended (Exhibits and page numbers)_____

B. Name, title, address, and telephone of officer or partner of applicant who is to receive compliance and informational communications from the Division of Workers' Compensation and is responsible for disseminating this information within the applicant's organization. This person will be contacted on matters involving this application.

Name:_____ Title:_____

Address_____ Telephone Number: _____

_____ Fax and E-mail _____

Exhibit C. Summary of Information in Application

1. Summary Description of Organization and Operation. Provide as Exhibit C-1 a summary description of the organization and operation of applicant's business as a workers' compensation health care provider organization, covering the highlights and essential features of the information provided in response to the other portions of this application which is essential or desirable to an effective overview of the applicant's workers' compensation health care business, including a summary of the applicant's experience in the provision of workers' compensation health care.

2. Summary Description of Start-up. Provide as Exhibit C-2 a concise description of applicant's start-up program and its assumptions, including such program's operating, capitalization and financial assumptions. Indicate applicant's projected date for the beginning of operations.

Exhibit D. Organization and Affiliated Persons

Check the boxes that apply to your organization:

1. Type of Organization. Please use the appropriate forms at the end of the application.

[ ] a. Corporation. If applicant is a corporation, attach WCHCPO Form-1, the Articles of Incorporation Bylaws, the Corporation Information and any other organizational documents or agreements relating to the internal affairs of the applicant.

[ ] b. Partnership. If applicant is a partnership, attach WCHCPO Form-2, the Partnership Agreement, the Partnership Information Form and any other organizational documents or agreements relating to the internal affairs of the applicant.

[ ] c. Sole Proprietor. If applicant is a sole proprietorship, attach WCHCPO Form-3, the Sole Proprietorship Information Form.

[ ] d. Other Organization. If applicant is any other type of organization, attach WCHCPO Form 1-D, Articles of Association, trust agreement, or any other applicable documents, organizational documents or agreements relating to the conduct of the internal affairs of the applicant, and Information Form for other than Corporations, Partnerships, and Sole Proprietorships.

2. Individual Information Sheet. Attach an Individual Information Sheet (WCHCPO Form-2) for each natural person named in any exhibit in Item D-1.

3. Please provide a summary list of directors and officers, day-to-day administrator, medical director and administrator of financial affairs.

List the names of all directors and officers of the Health Care Organization.

Name	Title

List name and title of individual designated to be the day-to-day administrator of the Health Care Organization.

Name | Title

Address | Telephone

List name, title, specialty and address of the medical director of the Health Care Organization.

Name | Title | Specialty

Address | Telephone

List name, title, and address of the administrator of financial affairs of the Health Care Organization.

Name | Title

Address | Telephone

4. Contracts with Affiliated Persons, Principal Creditors and Providers of Administrative Services.

a. Persons to Be Identified. Attach as Exhibit D-4-a, a list identifying each individual or entity who is a party to a contract with applicant, if such contract is one for the provision of administrative services to the applicant or any such party is an Affiliated Person or Principal Creditor (Rule 9771.60(c) and (j)) of the applicant. As to each such person, show the following information in columnar form:

(i) The names in alphabetical order.

(ii) The exhibit and page number of the contract (including loans and other obligations).

(iii) The type of contract or loan.

(iv) Each relationship which such individual or entity bears to the applicant (officer, director, partner, trustee, member, Principal Creditor, employee, administrative services provider, health care services provider, or shareholder).

5. Other Controlling Persons. Does any individual or entity not named as a contracting party in Item D-3 or any exhibit thereto have any power, directly or indirectly, to manage, influence, or administer the operation, or to control the operations or decisions, of applicant?

If the appropriate response to this item is "yes," attach as Exhibit D-5 a statement identifying each such person or entity and explaining fully such person's power or control, and summarizing every contract or other arrangement or understanding (if any) with each such person. (Each such contract should be submitted pursuant to Subsection D-4.)

6. Criminal, Civil and Administrative Proceedings. Within the preceding 10 years, has the applicant, its management company, or any Affiliate of the applicant (Rule 9771.60(c)), or any controlling person, officer, director or other person occupying a principal management or supervisory position in such organization, management company or Affiliate, or any person intended to hold such a relationship or position, been convicted of or pleaded nolo contendere to a crime, or been held to have committed any act involving dishonesty, fraud or deceit in a judicial or administrative proceeding to which such person was a party?

If "yes," attach a separate exhibit as to each such person designated in Exhibit D-6, identifying such person and fully explaining the crime or act committed. Also, attach a copy of the exhibit to any Individual Information Sheet required by Item D-2 for such individual.

Exhibit E. Contracts with Providers

1. Provide sample contracts between the Health Care Organization and providers furnishing occupational medical services including primary treating physicians, specialists and consultants. Provide any variations to sample contract.

2. Compliance with Requirements. Attach as Exhibit E a statement in tabular form for each provider contract, and for each standard form contract and its variations, if any, specifying the provisions of such contract which comply with the following provisions of the Act and rules

Section 4600.6	Rules 9771.6
4600.6(l)(8)	9771.70
4600.6(n)	9772 through 9778

3. Identify the mechanism by which payments will be made to providers and amounts of reimbursement.

Exhibit F. Contracts with other health care and related services.

1. Provide sample contracts between other health care and related occupational health services including, acute hospital services, ambulatory care, emergency services, ambulance service, and home health care, utilization review, workplace health and safety, return to work, case management, health education, occupational health nursing, administrative services, and evaluation. Provide any variations to sample contract.

2. Compliance with Requirements. Attach as Exhibit F a schedule in tabular form for each workers' compensation health care contract and each standard form workers' compensation contract, identifying the particular provision of such contract which complies with the sections listed below, covering also any variations made in standard form contracts. As to any provision which varies from the applicable provision of the Act or rules, identify such provision in Exhibit F.

Section 4600.5(e)(7)(B)	Rules 9771.67
4600.6(e)	9771.69
	9772 - 9778

3. Identify the mechanism by which payments will be made to providers and amounts of reimbursement.

Exhibit G. Advertising

Attach as Exhibit G a copy of any advertising which is subject to Section 4600.6 of the Code and which applicant proposes to use. With respect to each proposed advertisement indicate the contract(s) by name and by exhibit number(s) to which such advertisement relates.

Exhibit H. Marketing of Workers' Compensation Health Care Contracts.

Attach as Exhibit H a statement describing the methods by which applicant proposes to market workers' compensation health care contracts, including the use of employees, or contracting solicitors or solicitor firms, their method or form of compensation, and the methods by which applicant will obtain compliance with DIR Rules § 9771.64, 9771.65, and 9771.83.

Exhibit I. Supervision of Marketing.

Attach as Exhibit I a statement setting forth applicant's internal arrangements to supervise the marketing of its workers' compensation health care contracts, including the name and title of each person who has primary management responsibility for the employment and qualification of solicitors, advertising, contracts with solicitors and solicitor firms and for monitoring and supervising compliance with contractual and regulatory provisions.

Exhibit J. Solicitation Contracts.

1. Attach as Exhibit J-1 a list of all persons (other than any employee of the organization whose only compensation is by salary) soliciting or agreeing to solicit the sale of workers' compensation health care contracts on behalf of the applicant. Also provide the contracts with such persons. If the contract does not show the rate of compensation to be paid, specify the rate of compensation.

2. Attach as Exhibit J-2, a copy of each contract or proposed contract between applicant and the persons named in Exhibit J-1 for soliciting the sale of or selling workers' compensation health care contracts on behalf of applicant. If a standard form contract is used, furnish a specimen of the form, identify the provision and terms of the form which may be varied and include a copy of each variation.

Exhibit K. Workers' Compensation Health Care Contract Enrollment Projections.

Note: All projections are to cover the period beginning with the applicant's commencement of operations as an authorized and certified workers' compensation health care provider organization for the first two years.

1. Projections. Attach as Exhibit K-1 projections of applicant's enrollments made on the basis of commitment or letters of intent from workers' compensation health care provider contracts with self-insured employers, groups of self-insured employers, or insurers of employers (individually, "Employer"; collectively, "Employers") for the periods specified in the above note. Exhibit K-1 is to contain the following information with respect to each anticipated workers' compensation health care contract:

a. The name of the Employer.

b. The number of potential employees eligible to receive workers' compensation health care from the organization who are employed by the Employer.

c. The locations within and around applicant's service area in which the potential employees live and work.

d. The estimated date (or period after authorization and certification by the Division of Workers' Compensation of the Department of Industrial Relations) for entry into the workers' compensation health care contract.

e. Identification of the workers' compensation health care contract anticipated with the Employer, by reference to Exhibit F.

f. The projected number of employees on a monthly basis for the initial period specified in the Note, above, and quarterly for the following year.

2. Substantiation of Projections. Attach as Exhibit K-2 for each workers' compensation health care contract specified in Exhibit K-1 a description of the facts and assumptions used in connection with the information specified in that exhibit and include documentation of the source and validity of such facts and assumptions.

3. Letters of Interest. Attach as Exhibit K-3 letters of interest or intent from each Employer listed in Exhibit K-1, on the letterhead of the Employer and signed by its representative.

L. Organizational Chart. Attach an organizational chart as detailed in the instructions, including a chart demonstrating the structural relationships between the medical director, fiscal or financial administrator, and executive officers and administrators of the HCO.

.

L.1 Organizational Narrative. Describe (Exhibit L-1) the organizational chart in Item L.

L-2. Persons and Positions in the Organization. List below (Exhibit L-2) individuals, their position, time commitment, and describe the responsibilities and authority of key personnel identified in the organizational chart (Item L) or narrative (L-1)

Name	**Position**	**% Time**

Responsibilities and Authority

Name	**Position**	**% Time**

Responsibilities and Authority

Name	**Position**	**% Time**

Responsibilities and Authority

Name	**Position**	**% Time**

L.3 Separation of Medical Services from Fiscal and Administrative Management. Describe how medical decisions will be rendered by qualified providers unhindered by fiscal and administrative management of the HCO.

Exhibit M. Current Viability.

1. Financial Statements.

a. Attach as Exhibit M-1-a the most recent audited financial statements of applicant, accompanied by a report, certificate, or opinion of an independent certified public accountant, together with all footnotes to such financial statements.

b. If the financial statements attached as Exhibit M-1-a are for a period ended more than 60 days before the date of filing of this application, also attach as Exhibit M-1-b financial statements prepared as of date no later than 60 days prior to the filing of this application consisting of at least a balance sheet, a statement of income and expenses, and any accompanying footnotes; these more recent financial statements need not be audited, so long as they are prepared in accordance with generally accepted accounting principles.

2. Provision for Extraordinary Losses. The following requirements require an initial applicant to submit legible copies of the actual policies of insurance (including any riders or endorsements) or specimen copies of the policies of insurance which show all of the terms and conditions of coverage, or with respect to those items expressly allowing for self-insurance, allow applicant to provide evidence of self-insurance at least as adequate as insurance coverage.

a. Attach as Exhibit M-2-a evidence of adequate insurance coverage or self- insurance to respond to claims for damages arising out of furnishing workers' compensation health care (malpractice insurance).

b. Attach as Exhibit M-2-b evidence of adequate insurance coverage or self- insurance (e.g., appropriate reserve set aside to fund likely liabilities associated with uninsured costs) to respond to claims for tort claims, other than with respect to claims for damages arising out of furnishing health care services.

c. Attach as Exhibit M-2-c evidence of adequate insurance coverage or self- insurance to protect applicant against losses of facilities upon which it has the risk of loss due to fire or other causes. Identify facilities covered by individual policies and indicate the basis upon which applicant believes that the insurance thereon is adequate.

d. Attach as Exhibit M-2-d, evidence of fidelity bond coverage for at least the amounts specified in Rule 9771.74, in the form of a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Commissioner, providing 30 days' notice to the Administrative Director prior to cancellation, and covering each officer, director, trustee, partner and employee of the organization, whether or not compensated.

e. Attach as Exhibit M-2-e evidence of adequate workers' compensation insurance coverage against claims which may arise against applicant.

Exhibit N. Fiscal Arrangements

1. Maintenance of Financial Viability. Attach as Exhibit N-1 a statement describing applicant's arrangements to comply with Section 4600.6(m) of the Code and Rule § 9771.73.

2. Provider Claims. Attach as Exhibit N-2 a statement describing applicant's system for processing claims from providers for payment, including the rules defining applicant's obligation to reimburse, the standards and procedures for applicant's claims processing system (including receipt, identification, handling, screening, and

payment of claims), the timetable for processing claims, and procedures for monitoring the claims processing system.

3. Other Business. If the applicant is or will engage in any business other than as a workers' compensation health care provider organization, attach as Exhibit N-3 a statement describing such other business, its relationship to applicant's business as an organization, and the anticipated financial risks and liabilities of such other business. If the financial statements and projections in Exhibits M-1-a, do not include such other business, explain.

Exhibit O. Geographic Service Area

Exhibit O.1 In the manner described in DWC memo of April 18, 1996: **"File Specifications for Geo-Coding Provider and Employer/Worksite Locations for HCO Applications." :**

List all 5-digit U.S. Postal Zip Code numbers in the service area below . Use continuation pages if necessary.

Zip Code	Zip Code	Zip Code	Zip Code	Zip Code

P. Description of Health Care Arrangements. List the number of full-time equivalent physicians available for medical care under Workers' Compensation by specialty type (eg. allergy-immunology, anesthesiology, cardiology, dermatology, emergency medicine, family medicine, general medicine, gynecology-obstetrics, internal medicine, neurology, occupational medicine, oncology, ophthalmology, orthopaedics, doctor of osteopathy, otolaryngology, pathology, physical medicine-rehabilitation, psychiatry, pulmonology, rheumatology, surgery, urology, and any other).

Exhibit P-1: Number of Medical Providers and Support Staff

Provider Type	Number of Full-Time Equivalents
Medical Doctor (M.D./D.O.) Physicians	
Primary Treating Physicians:	
_____	_____
_____	_____
_____	_____
_____	_____
TOTAL	_____
Specialists:	
Allergists/Immunologists.....	_____
Anesthesiologists.....	_____
Cardiologists.....	_____
Dermatologists.....	_____
Gynecologists/Obstetricians.....	_____
Neurologists.....	_____
Occupational Medicine.....	_____
Oncologists.....	_____
Ophthamalogists.....	_____
Orthopedists.....	_____
Otolaryngologists.....	_____
Pathologists.....	_____
Physical Medicine/Rehabilitation.....	_____
Psychiatrists.....	_____
Pulmonologists.....	_____
Radiologists.....	_____
Rheumatologists.....	_____
Surgeons.....	_____
Hand.....	_____
Back.....	_____
General.....	_____
Plastic.....	_____
Urologists.....	_____
Other: _____	_____
TOTAL	_____

P2. Acute Care Facilities. Exhibit P-2: List all HCO-operated or contracting hospitals with their bed capacity. Use continuation pages, if necessary.

Name of Hospital and Address	License Number	Bed Capacity

Exhibit P-3: Number of Non-M.D./D.O. Providers and Support Staff

Provider Type	Number of Full-Time Equivalents
Non-Medical Doctor (M.D./D.O.) Physicians	
Acupuncturists	_____
Chiropractors	_____
Dentists	_____
Optometrists	_____
Podiatrists	_____
Psychologists	_____
Support Staff	
Case management workers	_____
Heath Educators	_____
Nurse Practitioners	_____
Occupational Nurses	_____
Occupational Therapists	_____
Pharmacists	_____
Physical Therapists	_____
Physician Assistants	_____
Registered Nurses	_____
Respiratory Therapists	_____
Social Workers	_____
Vocational Rehabilitation counselors	_____
Other: _____	_____
Other: _____	_____
Other: _____	_____
Other: _____	_____
Other: _____	

Exhibit P-4. Calculation of Physicians per 1,200 Expected Injuries and Illnesses. Furnish the calculation of the number of primary treating physicians per 1,200 expected injuries and illnesses per year. Define primary treating physicians. Describe the methodology, data, and list assumptions used in the calculation of expected number of injuries.

Exhibit P-5.1 Standards of Accessibility. Describe the standards of accessibility for HCO enrollees, including availability of appointments for primary and specialty care for HCO enrollees residing in and out of the geographical service area, after hours and emergency services, anticipated or actual patient waiting times, and the system for monitoring and evaluating accessibility.

Exhibit P-5.2 Interpreters' Services. Describe how the HCO will make available interpreters' services, as required, for the treatment and evaluation of patients.

P-6. Medical Case Management: Initiation of Treatment, and Coordination of Referrals and other Aspects of Medical Treatment. Describe in detail the personnel and process for how treatment is initiated, how the HCO will coordinate with the claims administrator to initiate, deny or modify treatment; describe how an HCO enrollee is assigned a primary treating physician, and the process of medical case management, coordinating and monitoring referrals to consultants, therapeutic or diagnostic facilities, reporting of treatment, responding to patients' request for change of physician or second opinion, and ensuring the timeliness of referrals. Include in the description the procedure by which HCO enrollees may be referred to chiropractors.

P-7. Occupational Health Expertise and Education.

a. List the physician(s) with board certification in occupational health who are on staff or contractors to provide expertise on workplace health and safety and prevention and treatment of occupational illnesses or injuries.

Name	**Title**	**Specialty**
Address		Telephone
Name	**Title**	**Specialty**
Address		Telephone
Name	**Title**	**Specialty**
Address		Telephone

b. Describe in detail the HCOs educational program, addressing how primary treating physicians receive education, training and experience in occupational medicine and workers' compensation. Use continuation pages, if necessary.

P-8. Workplace Safety and Health. Describe in detail the capability to work cooperatively and in conjunction with employers, employees, and claims administrators to promote workplace health and safety, including education of employers and employees, consultation on employee medical screening for early detection of occupational disease, prompt reporting of specified conditions.

P-9. Return to Work. Describe in detail the personnel and process in the return-to-work program for patients and how it will be coordinated with employers, employees, and claims administrators to promote early and sustained return-to-work without re-injury.

P-10. Evaluation. Describe the method to report data, including costs of services specific to particular occupations, diagnoses, and procedures; aggregated information on number of enrollees by demographic and industrial characteristics; and data to evaluate patients' return to work.

Q. Reserved for Future Use

R. Internal Quality of Care Review System. As Exhibit R-1a attach an organizational chart showing the key persons, committees and bodies responsible for the conduct of the review system.

R-1. Organization and Operation. As Exhibit R-1b describe the goals and objectives, organizational arrangements, methodology for monitoring and evaluation, and scope of the internal quality of care review system.

R-2. Standards and Norms. As Exhibit R-2 describe the standards and norms of the system. Include guidelines for chiropractic care and the definition of the HCO's definition of "neuromusculoskeletal condition." Describe the process whereby the medical reasonableness/medical necessity of requests for authorization are reviewed and decisions on such requests are made by the HCO; the method to assure that all reports used to determine workers' compensation benefits are prepared in an objective, fair, and unbiased manner; how workplace health and safety promotion (P-8) and return to work coordination (I-9) will be assessed in the quality review program.

R-3. Operation of the System. As Exhibit R-3 describe the operation of the review system, including the frequency and scope of audits. Describe the manual and automated data storage and retrieval systems for medical and utilization review, and the types of data analyses and reports, and the manner in which results are communicated to providers and the HCO's governing body. Describe the method for incorporating the results of surveys of enrollees and patients to evaluate the HCO.

R-4 Administration of the Review System by Contract Providers. As Exhibit R-4 describe any portion of the review system that is administered by contracting providers, affiliates, or other entities that are not officers or employees of the HCO.

R.5 Monitoring of Provider Administration. As Exhibit R-5 describe the contractual arrangements to enable the HCO to monitor, and require compliance with the quality of care review system, to the extent the review system is administered by contracting providers.

S. Contracts with Employers. Provide sample contracts between the Health Care Organization and employers/insurers purchasing occupational medical and health care and related services. Actual contracts that substantially differ from the sample must be promptly amended to an application.

S.2 Contracts with Claim Administrators. Provide sample contracts between the Health Care Organization and claims administrators (insurance carrier) for the furnishing of occupational medical and health care and related services, including provisions for coordinating data collection and coordination of the workplace health and safety promotion activities. Actual contracts that substantially differ from the sample must be promptly amended to an application.

T. Evidence of Coverage for HCO Enrollee/Patient Assistance and Notification. Describe the materials and methods of communicating to HCO enrollees the details of their coverage, and how to access services. Provide draft copies of enrollment and member materials. Describe how patient education specifically designed for injured workers will be provided.

U. Reserved for Future Use.

W-1. Provider/Enrollee Grievance Procedure. Attach a copy of the written grievance procedure, including the procedures for expedited review of medical reasonableness or medical necessity.

W-2. Complaint Forms and Patient/Provider Explanation. Attach a copy of the complaint forms used by HCO enrollees and HCO providers along with the written explanation.

W-3. Persons and Positions in the Organization. List below individuals, their position, time commitment, and describe the responsibilities and authority of key personnel for carrying out grievance procedures.

Name	Position	% Time

Responsibilities and Authority

Name	Position	% Time

Responsibilities and Authority

Name	Position	% Time

Responsibilities and Authority

Name	Position	% Time

Responsibilities and Authority

Name	Position	% Time

Responsibilities and Authority

FORMS
STATE OF CALIFORNIA
DIVISION OF WORKERS COMPENSATION

CORPORATION

INFORMATION FORM

To be used in response to Item D.1.a -- WCHCPO Form-1.

1. Name of Applicant (as in Item 1-a) _____

2. State of Incorporation._____

3. Date of Incorporation._____

4. Is applicant a nonprofit corporation? ( ) Yes ( ) No

5. Is applicant exempted from taxation as a nonprofit corporation? ( ) Ye

6. Names of principal officers, directors and shareholders. List (a) each person who is a director or principal officer or who performs similar functions or duties and (b) each person who holds of record or beneficially 5 percent or more of the voting securities or more of any class of applicant's equity securities. If this is an amended exhibit, place an asterisk (*) before the names for whom a change in title, status or stock ownership is being reported and a double asterisk (** before the names of persons which are added to those furnished in the most

Full Name			Beginning Date		Relationship		Class
Last	First	Middle			Title or Status	Mo.	Year of

7. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

_____
_____
_____
_____

STATE OF CALIFORNIA
DIVISION OF WORKERS COMPENSATION

PARTNERSHIP

INFORMATION FORM.

To be used in response to Item D.1.b -- WCHCPO Form 1-B.

1. Name of Applicant (as in Item 1-a): _____

2. State of organization: _____

3. Date of organization: _____

4. Names of Partners and Principal Management: List general, limited and special partners and all persons who perform principal management functions. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in status or partnership interest is being reported and place a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

Full Name			Beginning Date	Type of Partner
Last	First	Middle	Mo. Year	

5. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

_____
_____
_____
_____

STATE OF CALIFORNIA
DIVISION OF WORKERS COMPENSATION

SOLE PROPRIETORSHIP

INFORMATION FORM

To be used in response to Item D.1.c -- WCHCPO Form 1-C.

1. Name of Applicant (as in Item 1-a).

2. Residence Address:

3. Names of persons performing principal management functions. List each person who occupies a principal management position or who performs principal management activities for the applicant. If this is an amended exhibit, place an asterisk (*) before the names of persons whose title or duties is being reported and a double asterisk (**) before the names of persons which are being added to those furnished in the most recent previous filing of this exhibit.

Full Name			Beginning Date		Title and Duties
Last	First	Middle	Mo.	Year	

4. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

STATE OF CALIFORNIA

DIVISION OF WORKERS COMPENSATION

INFORMATION FORM FOR MISCELLANEOUS TYPES OF ENTITIES.

To be used in response to Item D.1.d -- WCHCPO Form 1-D.

1. Name of Applicant (as in Item 1-a)

_____

2. State of Organization_____

3. Date of Organization_____

4. Form of Organization (describe briefly)

_____

5. Names of Principal Officers and Owners: List below the names of (a) each person who is a principal officer or trustee of the applicant or who performs principal management functions and (b) each person who owns of record or beneficially over 5 percent of any class of equity security of the applicant. If this is an amended exhibit, place an asterisk (*) before the name of each person for whom a change in title, status or interest is reported, and a double asterisk (**) before the name of persons which are added to those reported in the most recent pr

Full Name			Beginning Date	Class of Equity	Percent of	Title of
Last	First	Middle	Mo. Year		Security %	Class

6. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

_____

_____

_____

Authority: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4

Section 9771.63 Individual Information Sheet (WCHCPO Form 2).

An individual information sheet required pursuant to these rules shall be

CONFIDENTIAL
DIVISION OF WORKERS COMPENSATION
State of California
INDIVIDUAL INFORMATION SHEET
under Labor Code Section 4600.6

File No._____

1. Name of Applicant:

_____

2. Exact full name of person completing this statement:

_____
First Middle La

1. Have you ever had a certificate, license, permit registration or exemption issued pursuant to the Business and Professions Code, Health and Safety Code, Insurance Code, or Labor Code denied revoked or suspended or been otherwise subject to disciplinary action while you were in the employ of the applicant or while you had a contract with the applicant as a provider or otherwise? [ ] Yes [ ] No

If "yes" state the date of the action and the administrative body taking su

_____
_____
_____

4. Have you ever been convicted or pled nolo contendere to a misdemeanor involving moral turpitude or any felony, other than traffic violations? [ ] Yes [ ] No

If the answer is "yes" give details:

_____
_____
_____

5. Have you ever changed your name or ever been known by any name other than that herein listed? (Including a married person's prior surname, if any.) [ ] Yes [ ] N

If so, explain. Change in name through marriage or court order must be listed. EXACT DATES OF EACH NAME CHANGE MUST BE LISTED.

_____

_____

_____

6. Have you ever engaged in business under a fictitious firm name in the past, either as an individual or in the partnership or corporate form? [ ] Yes [ ] No

If the answer is "yes" set forth particulars:

_____

_____

_____

VERIFICATION

I, the undersigned, state that I am the person named in the foregoing Individual Information Sheet, that I have read and signed said Individual Information Sheet and know the contents thereof including all exhibits attached thereto; and that the statements made therein and in the exhibits attached thereto, are true and correct.

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this Individual Information Sheet and know the contents thereof, and that the statements therein are true and correct.

Executed at _____ on _____
(Place) Date)

_____
(Signature of Declarant)

Note: If this form is signed outside California complete notary public jurat in the space provided below.

State of_____

County of_____

Dated,_____

at_____

_____
(Signature of Affiant)

Subscribed and sworn to before me,

_____, _____
Notary Public in and for said

County and State

Authority: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4